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ORIGINAL COMMUNICATIONS.

PURPURA.

BY J. H. BUNDY, M. D., OAKLAND, CAL.

THIS is a disease in which the blood or the capillary vessels throughout the system, or both, are altered, but the real nature of the change is as yet not well determined. There is evident constitutional disturbance throughout the disease, manifest by disorders of the digestive, the assimilative, and the excretory functions, attended by languor and debility; but it is a disease usually unattended with fever, which, however, does sometimes occur, and the disease is termed *acute purpura*. The capillaries of the cutaneous and mucous surfaces are more especially implicated. Small round spots are visible on various parts of the surface, of a dull red or a deep purple color. These are due to ecchymosis from the cutaneous capillaries beneath the cuticle through which the color shines, and are of small size, except where they run together in patches.

Hemorrhages from mucous membranes are common, also extravasations of blood within the substance of the several viscera. Many have considered this disease identical with scurvy, and for this reason the appellation of "land scurvy" has been given it. Others have regarded it as a skin disease

—*purpura simplex*. It has also been termed *petechiæ sine febre*, because the spots are not connected with continued fever. The disease is closely related to *hemorrhages* as a morbid state on the one hand, and to *scurvy* on the other; and therefore there may be distinguished two varieties—*simple* and *hemorrhagic*, which latter is thus defined when accompanied by hemorrhage from a mucous surface. It has not been determined what is the true nature of the morbid state essential to purpura. In some cases the urine has been observed to contain an excess of albuminous matter, with a deficiency of urea. The blood has been found deficient in coagulating power. A great source of danger attending this disease is the occurrence of extravasation of blood into the internal organs.

The lungs, the brain, the liver and the alimentary canal, are the most frequently affected. Purple spots and effusion of blood are to be found on the serous membranes, as in the *arachnoid*, the *pleuræ*, the *pericardium*, the *peritoneum*; and occasionally the blood lies coagulated in the cavities of the membranes. It has also been found in the bladder and in the calyces and pelvis of the kidney. The causes are not well understood or known, though more frequently a disease of women than men; and, in boys before than after puberty. Probably poor living—a low state of the blood, and in fact a tendency to sepsis. From a careful study of the disease, I regard sepsis, or that state of the blood that engenders sepsis the cause of *purpura*. Poor living is not always the cause of sepsis when associated with purpura. For instance: while attending a course of lectures at the Chicago Medical College, in the winter of 1867–8, my wife was taken with chills and fever with swellings on the tibial and ulnar surfaces, looking as though the spines of those bones had been bruised and pounded, with green or black and blue spots appearing as large as a small hen's egg, very sore, very painful, could not sleep for the excessive pain, etc. Having at that time practiced medicine seven years, I did not know what to make of the case. I finally called in Prof. N. S. Davis, Prof. of Theory and Practice of Medicine in the college, to see what

the trouble was. After about twenty minutes deliberation he pronounced it a case of acute purpura. I said, "Doctor, I have studied the case carefully for thirty-six hours, and I do not know what it is, nor how to treat it." Says the Doctor, "It is a case of acute purpura, and older heads than yours have failed to diagnose it." The disease lasted about five days, and the remedies prescribed were as follows :

R Tr. Stramonium, $\bar{3}j$;
Tr. Veratrum Vir., gtts. xx.

M. S. Take ten drops every 3 hours.

R Tr. Ferrichlor, $\bar{3}ss$;
Potass Chlor, $\bar{3}j$;
Syr. Simp;
Aqua, $\bar{a}\bar{a}$ qs., ad. $\bar{3}iv$.

M. S. Teaspoonful every 3 hours.

She improved immediately, and in five days was well. In from seven to eight days from the time she was attacked, she made a recovery. This was without doubt, as the doctor said, a case of acute purpura. A physician may, perhaps, follow a life's profession and never see a case of this kind. In fact, I have never seen a case of the same kind since. As to the treatment, I should always resort to Baptisia, Phytolacca, Tr. of Iron, Chlorate of Potash; and stick to those as the remedies to be depended upon, and as the remedies [that will always control that peculiar state of the blood that attends purpura.

CONJUNCTIVITIS.

Granular Conjunctivitis — Ophthalmia Granulosa — Trachoma.

BY F. CORNWALL, M. D., BUTTE, MONTANA.

As previously remarked in another chapter, there are two distinct forms of this disease. The first which occurs as a result of conjunctivitis and is marked by papillary engorgement, and may be called *papillary granulations*. The second is more essentially a chronic affection, may occur without inflammatory symptoms, and is a follicular disease of the con-

junctiva, and may be called *follicular granulations*. It is not uncommon that both forms exist at the same time. Papillary granulations occur, usually as a complication, or as a result of some form of acute conjunctivitis, and as a matter of course, are confined to the papillary portion of the conjunctiva. The papillæ of the conjunctiva begin about one line from the inner lip of the lid, and are extremely fine, but as they continue toward the palpebral fold, increase in size. They terminate about a line beyond the upper and inner border of the cartilage. When there is inflammatory action these papillæ become hypertrophied. Their appearance is usually of a uniform color over the whole surface, sometimes bright red, and at others deep red or even of a bluish tint.

The second or follicular form may arise without inflammatory precedent. The granulations from their gelatinous translucency and shape are said to resemble the spawn of a frog. To a physician familiar with the appearance of follicular pharyngitis it will not be difficult to diagnose a similar form of disease in the conjunctiva. In a bad case of follicular trachoma, should the lids be everted, the swelling of the palpebral fold will be found very great, and appears like a large tumor with a surface thickly coated with spawn-like granules.

These granules have a variety of appearances as to color and size, in this respect the opposite of the papular form. The conjunctiva between these granules is smooth, but deeply injected. More frequently, however, fine papillary granules can be discovered showing a tendency to assume the form of a mixed trachoma.

In mixed and diffuse trachoma, a combination of the two conditions are present. When the disorganizing effect of trachoma extends to the integument and cartilage of the lids and to the cornea, and where extensive neoplastic formations occur in and upon the conjunctiva, it is termed diffuse trachoma. The whole lid becomes hypertrophied and clumsy in its movements. The palpebral fold is greatly flattened and filled with granulations. The conjunctiva becomes relaxed and forms folds or duplicatures in its structure.

There are a variety of conditions and morbid symptoms, that cannot, owing to the necessary brevity of these articles, be enumerated or described. There may arise herpetic or phlyctenular disease which may effect the treatment as well as the general course of the case. To illustrate: I examined and prescribed for a case of mixed trachoma. The patient upon his return home was advised by his friend not to use the medicine as it might do serious injury to the eye. He followed his friend's advise, and as a precautionary measure procured a bottle of Thompson's eye-water. In the course of two months his eye became much worse, when he reapplied to me for treatment. Feeling a little indignant toward him for the way in which he had treated me, and being in something of a hurry, I told him to use the medicine I had first prescribed, without making an examination. He did as I bade him, but the eye kept getting worse for a couple of days, when I made an inspection of his eye. There was deep injection of the conjunctiva, photophobia and lachrymation, and on the cornea at the *limbus conjunctivalis* a well defined row of herpetic vesicles. I directed my treatment to the corneal disease, which in a few days disappeared. I then resumed the treatment for trachoma and the case rapidly recovered.

The causes of trachoma are various, as in other conjunctival inflammations. In many cases it is purely a local affection, being caused by external irritants. Depraved conditions of the system certainly favor the disease, as does refractive difficulties of the eye. In mountain countries where sunlight is very bright, trachomatous irritations from sympathy with the intraocular disturbance are often produced. Direct inoculation with the secretion from an eye affected with the disease is a very common cause. It is to be remembered that the disease is contagious in almost any of its forms.

The milder cases of trachoma, especially of the papillary form, often get well spontaneously, but the mixed and diffuse varieties have but little tendency in that way. There may result a variety of disabilities such as cicatrices, adhe-

sions, tendonous and fatty degeneration, etc. The cornea may be left xerotic and hazy. A common result of trachoma is turning in or out of the lids—entropion and ectropion. Wild hairs, distichiasis and trichiasis is also produced by a perverted nutrition of the lids in the region of the hair bulbs.

The treatment of trachoma requires considerable of tact, and is thought to be by some very difficult to cure. Stellway says the principal means of cure is the scissors, nitrate of silver and sul. of copper, and I think a great many American oculists have never advanced any further. Acute papillary granulations as an accompaniment of inflammatory affections of the conjunctiva, may be attacked with nitrate of silver (grs. xl, ad. ʒj), neutralizing the chemical soon after its application with a mild salt and water solution. The application should not be made oftener than once a day, and probably once in three days will be sufficient. In the interim such other treatment as is indicated should be administered.

In chronic cases of follicular or mixed trachoma, such constitutional and hygienic treatment should be ordered as the condition of the system would seem to indicate. Iod. of Potassium and Ammonium are the most reliable agencies, but their efficiency is undoubtedly heightened by the addition of podophyllum, iris, stillingia and xanthoxylum. The local remedies should be milder than those usually recommended. For a number of years when I first commenced the practice of medicine, I used to try to cure trachoma with *blue stone*, nitrate of silver, nitric acid C. P. applied with a pine stick, scalpel and scissors, etc., but do not recollect of having cured or even of having benefited a case. In the treatment of isolated cases these means are occasionally necessary, but for a main reliance will result disastrously to any physician who uses them.

In mild cases of mixed trachoma without vascular injection, and where the granules are but slightly developed, the following is a reliable combination:

R Cupri sul. grs. x;
Aurii chloridi, grs. j;

Aquæ, ʒj.

M. Apply with a camel's hair brush once a day.

In mixed and diffuse trachoma where the vascular injection is great, Goulard's solution of Plumbi sub. acetate is the remedy indicated, and should be applied in its purity, with a camel's hair brush once a day. Should the eye not tolerate it so often, use every two or three days. Should there be from any cause an abrasion of the cornea, this remedy should not be used until it can be healed.

It is not uncommon that after using these remedies for several weeks they cease to have their salutary effect, and it becomes necessary to make a change. When there are large gelatinous granulations, or a stubborn irritability that resists the mild sedative treatment, nitrate of silver (xx or xl grs. ad. ʒj) should be used once or twice a week as previously directed. In the interim use the following:

R Sul. Hydrastia,
Sul. Zinc,
Sul. Morphia, āā grs. ij;
Aqua Glycerine, ad. ʒss.

M. Sig. Drop in the eye two or three times a day.

In ancient cases of trachoma the conjunctiva may have become degenerated until the effect of treatment is not noticeable. It is permissible to clip with scissors large cauliflower granulations, but in doing this it is necessary to avoid wounding the conjunctiva. A few days after the clipping process, the remaining base of the granules may be touched with a very strong solution of nitrate of silver. Should there result any inflammatory action, cold packs should be applied over the lids and the eye be given rest.

The conjunctivitis of infants receive the name of ophthalmoblenorrhoea and ophthalmia neonatorum. As in the adult, the ophthalmia of infants may assume a variety of forms, but the greater number are decidedly blennorrhoeal in their character, and owing to the delicacy of the infantile tissues, the effect as well as the treatment of this disease is considerably modified.

The palpebral fissure is apt to be closed with the intensity of the swelling, and eversion will likely take place should there be an attempt to open the eye. In the catarrhal form the swelling takes the form of conjestive ordema, but in blennorrhea the conjunctiva is intensely chemotic. There is severe pain, photophobia and active febrile action; after secretion commences the pain and sensitiveness will decrease. The constantly flowing profuse secretion will excoriate the integument of the lids and cheeks and produce severe inflammatory action. The causes of ophthalmia neonatorum are various. The maternal secretions, exposure to bright light, uncleanliness of child and attendants, bad air and by inoculation. The active inflammatory symptoms reach their height in from five to eight days. A cure need not be expected short of eight days, and in bad cases, or those which are badly treated, a number of weeks may be occupied before the eye can be brought to a normal condition.

As in the adult, the severity of the inflammatory action will determine the injurious results of the disease. The tendency of infantile blennorrhea to extend to the cornea increases its destructability. The indications for treatment are not different from those of the adult in the same affection, but the means and facilities of applying them are changed on account of not having the control of our patient's movements. A physician may become meddlesome from a desire to ascertain the particular condition of the eye, or to apply a remedy thoroughly. The exceeding delicacy of the infantile organism, and the spasmodic closure of the lids at such times, make it imperative that the greatest degree of gentleness and judgment be exercised in the treatment of a case. Every precaution should be used that there is in adult cases in regard to ventilation and shading of apartments; cleanliness in every respect should be imperative. In mild cases we should use remedies sparingly for fear we do too much and thereby aggravate the case. To relieve severe inflammatory symptoms a weak solution of sul. of atropia may be used, and as secretion commences permanganate of potash ($\frac{1}{4}$ gr. ad. $\bar{3}j$) should

be dropped in the eye several times a day. Sulphate of hydrastia is an admirable remedy in these cases, and may be used freely. In mild cases I should use it first as it is less apt to do harm than most other reliable remedies. Boracic acid is a remedy that promises good results, and may be tried in an aqueous solution (5 grs. ad. ʒj); I use it in other forms of blennorrhea in combination with sulphate of hydrastia with good results. Oculists of renown laud very highly nitrate of silver in weak solution (1 to 3 grs. ad. ʒj). To cleanse the eye let the lids be separated gently with the fingers, and warm soft water be trickled from a sponge over the lids. Another sponge may be placed in such a position as to catch the overflow of water. When the washing is finished the eyes are to be dried with absorbent cotton.

VARIOLA.

BY J. H. BUNDY, M. D., OAKLAND, CAL.

VARIOLA is the result of a specific and palpable morbid poison, which is multiplied and reproduced during the course of the disease. After a definite period of incubation, a remittent fever is established, followed by an eruption on the skin, and often on the mucous surfaces, with other concomitant and occasionally succeeding affections. The eruption passes through four stages, that of pimple, vesicle, pustule, scab, and leaves marks or scars on its site. It runs a definite course, and as a rule, exhausts the susceptibility of the constitution to another attack.

This disease has been prevailing in Oakland and San Francisco for the past six months to a considerable extent; not as an epidemic, but more as an endemic, though not very severe and with a small mortality when the number of cases are taken into consideration.

The theory regarding the development of this disease is, that a specific poison is absorbed and infects the blood, and after a period of latency gives rise to "primary fever" which lasts from two to four days, till the eruption appears, when the fever for the most part remits. The secondary or specific

action of the poison of small-pox makes itself obvious by an eruption on the skin, and also, sometimes on the mucous membrane of the eyes, nose, mouth, fauces and large intestines.

The eruption runs a given course, as follows: pimple, vesicle and pustule, and when fully out, or at its height, the febrile phenomena, which had remitted, return and give rise to what is termed the *secondary fever*.

The occasionally succeeding morbid conditions are inflammation of the various tissues of the lungs, of the urinary organs, and lastly, of the areolar tissue of the body generally, which often becomes the seat of an endless number of abscesses.

The occurrence of fever preceeding the secondary or specific actions of the poison, or the appearance of the eruption, has scarcely an exception, and indeed, in some instances it has been of so severe a character as to have destroyed the patient on the first onset.

The remission or subsidence of the fever is constant in mild cases, but in the severer forms of the confluent small-pox it sometimes runs on, and is constant.

The recurrence of the "secondary fever," and the exacerbation of the fever in severe cases at the time of the maturation of the pustule is also constant.

The cause of this secondary attack has long been a difficulty in the pathology of small-pox. Some attribute the fever to the specific nature of the disease, while others consider it to result from the maturation of the pustules, and really to be a suppurative fever—symptomatic and dependent upon the local affection.

The development of small-pox is traceable through certain stages, namely: 1. The period of incubation; 2. The febrile stage, or primary fever; 3. The exudative stage, or period during which the eruption appears and becomes fully developed; 4. The suppurative stage, or period of secondary fever. The eruption has itself certain definite stages in its development. It runs a given course of about eleven days, and in its progress undergoes many mutations. It is at first a pimple, then a vesicle, then a pustule, and lastly

it forms the crust or scab. The first, or stage of pimple, lasts from twenty-four to forty-eight hours; the second, or vesicular stage, four days; the pustular stage, three days; while the last stage, or that of scabbing, lasts three days more, making the whole duration of the *normal* pustule, ten or eleven days. There are, of course, two varieties of small-pox—*discrete* (distinct) and *confluent* (coalescing or running together). The eruption does not appear over the entire body at once, but appears in the successive crops. The first covers the face and neck, and upper extremities; the second, the trunk; while the third the lower extremities. When the eruption on the face is declining, that upon the extremities has scarcely arrived at its height, so that hands and feet are then considerably swollen. This may be regarded as a favorable sign, in so far as it indicates a certain vigor of the constitution. Some authors give as many as *eight* varieties, when in fact *two* cover the entire ground,—unless we wish to be *polytechnic* and bewilder instead of plainly stating simple facts that are only and mainly sought. When we say *discrete* and *confluent*, we have said all that is necessary concerning actual varieties; but to spin the thread finer, as some are always inclined to do, I will simply *mention* the eight, although I see no use of such minutiae. They are as follows: *Variolæ sine eruptione*; *Variolæ discretæ*; *Variolæ confluentes*; *Variolæ semi-confluentes*; *Abortive*; *Petechial*; *Hemorrhagic*; *Corymbose*. The symptoms of the discrete and confluent are the same in kind but differ in degree; and this is true of the treatment as well. In the simple or discrete the treatment would be quite different as to the quantity of medication were the same drugs used. The simple form requires little more than thorough ventilation, proper food and frequent bathing with saline laxatives, and quiet in bed, etc.; while the confluent would demand quite an active and prompt form of treatment. If malignant in character, denoted by the tendency to sepsis—*Baptisia*, *Phylotacca*, etc. If the pulse are full and bounding, *Veratrum* in full doses, with *Aconite* or *Gelseminum*, whichever may be indicated, with

acetate or nitrate of potassiae, in full doses. Sponge or cleanse the skin once or twice daily, and give the patient the coldest air possible to breathe, at the same time keep the patient thoroughly covered and warm in bed. It makes no difference how cold the air the patient *breathes*, if he is only in bed warmly covered, and *is* warm. Tonics are in order, and should always be given, and, in fact, are always indicated in the last stages of the disease, and quinine is probably the best, given in one grain doses three times daily.

As to the prevention of pitting attending small-pox I shall not speak, as it is not necessary from the fact of its so frequently being given. At the same time they all frequently fail, and the pitting occurs as frequently as do the cases. To sum up and give the facts: tonics, stimulants, bathing, ventilation, and other methods referred to, are the necessary points to be observed in any and all cases of small-pox.

EDITORIALS.

JUNE MEETING.

THE programme for the meeting of the State Society which takes place at Oakland on the second Tuesday in June, has not been received for publication, owing to the reports from the different bureaus not being complete. It will appear in the May number. A general invitation is extended to all the members of the Society to contribute one or more articles, which we hope they will report to the Secretary without delay.

From the papers that are already received, we can assure the members that it will be the most interesting meeting ever held by the Society.

These meetings can be made very beneficial if we earnestly devote even a short time to their success. Interchange of views promotes new ideas, and social intercourse gives broader views of life. The relaxation from the busy cares of a professional life will do good, and enable the practitioner to re-

turn to his field of labor with new resolves, higher aims and noble purposes. Men get selfish and narrow-minded if they continue without variation in the same rounds of duty and lines of thought. They forget the vast world and broad humanity that live and move beyond their sphere.

It gives a physician a better standing among his patrons if he at least yearly meets his brethren in council. They will look on him as more progressive, and anxious for their welfare than he who stays at home. Come and let us meet together, in one happy circle, and promote the interests of eclectic medicine in our beloved State.

MUST THE TRUTH BE TOLD?

FALSEHOOD and misrepresentation may for a time succeed, but he who builds on such a foundation will find that misfortune will sooner or later overtake him. Deception is a tinsel that will not stand the wear and tear of use. However beautiful an object of that kind may appear, time will reveal the brass of pretense. A mask may hide the face of treachery until emboldened with success, it is with defiance cast aside, and the skeleton of a bad life stands before you in all its ghastly hideousness.

We believe in the old adage, "honesty is the best policy." We believe in telling the truth, though at times it may be unpalatable. We have from time to time in this JOURNAL taken exceptions to the conduct of some of our so-called eclectics. Some people think we should not do so, especially the guilty. They think it is furnishing materials for our defamers to throw back at us. These are but faint-hearted friends—people who love their ease and hate to be disturbed. If eclectics are guilty of misconduct, we feel under no obligations to shield them. More than that, we feel it to be our duty to expose them. We want to draw the dividing line between honor and dishonor—fraud and justice—reputable practice and quackery—those who bought their diplomas and perjured themselves, and those who honestly earned them in the regular course of study. This object we shall accom-

plish. The intruders and pretenders shall have to stand on the left, the chaff separated from the wheat, and the dross from the pure gold.

Everybody knows that there are quacks and frauds in the eclectic ranks. We don't pretend to deny it. There would not be if we could help it. We are not to blame in the matter. But quacks and frauds are just as numerous in the other schools. They are deeper in the mud than we are in the mire, and cannot say to us we are purer and holier than you. We do not care what other schools may say or do, we will do what we conceive to be right. Our guide shall be our conscience, and our motto the eternal principles of right, truth and justice.

We are satisfied that we are doing a good work. That there has been an awakening in the eclectic conscience we have satisfactory evidence. The unsanctified are squirming, but die they must. We shall keep on in this line, until frauds shall cease to flourish, and pretenders are banished from our ranks. We have commenced the warfare. It shall not cease until the eclectic banner waves only over the heads of honest, upright men.

SELECTIONS.

ENTERECTOMY OR ENTERORRHAPHY.

AT the recent meeting of the Paris Surgical Society (Gazette des Hôpitaux, Feb. 2), there was an interesting discussion on this subject, excited by a report from St. Perier of a case where he had resected about eight inches of gangrenous intestine in a case of strangulated hernia, reduced *en masse*. The patient was fifty-two years of age, a cook, and the hernia was an inguinal one, usually easily reduced. The patient after a difficult reduction was seized with vomiting and symptoms of peritonitis. The phenomena of strangulation decided Dr. Perier to practice laparotomy in the median line. The operation was performed in the evening, with all antiseptic precautions. Arrived at the part affected he excised all the

affected part, performing subsequently enterorrhaphy. The patient died thirty-two hours after the operation. Post mortem examination showed that the sutures had held well, that re-union had already begun, and that the intestine offered no opposition to the passage of fæcal matter.

Dr. Trelat said he had performed intestinal suture three times after resection of the intestine. Gely's suture, made by means of a thread furnished with two needles, acts very well from the stand-point of bringing the two surfaces together, but if the thread be not drawn enough the operator fails to obtain sufficient approximation; on the other hand, if the thread be drawn too much, stricture of the intestine results. For these reasons Trelat preferred the suture with separated points. Kocher, of Berne, who in one case resected seventeen inches of intestine, observed that there was often a stricture of the lower end; to avoid this complication the end was dilated with a special speculum; often in approaching the two ends a species of mesenteric puckering resulted, which might be a point of departure for future trouble. This should also be restricted. Dr. Defries had examined the resected part, but did not think it affected with gangrene, although extensive inflammation existed. Several times in place of resecting had he reduced strangulated hernia, and the results were often good. Another theory of interest in this connection was that after hernias were reduced or operated on, patients often continued to present symptoms of strangulation, which were often due to temporary intestinal paresis. Dr. Le Fort held that to restore to the abdomen diseased intestine was strictly contra-indicated. Dr. Beyer had recourse, in cases of these kinds, to Lenberg's suture (with separated points) with the result of obtaining a marked stricture at the inferior portion of the re-united intestine. He had taken in the suture the whole of the intestinal parasites although Lenberg recommends only that the muscular and serous coat be taken, the mucous to be left alone; still he believed the stricture was principally due to Lenberg's suture. Dr. Marc See gave, like Dr. Trelat, the preference to Lenberg's suture, over that of Gely, but when

he used the first he multiplied the suture points. There was another precaution to take, the upper part of the intestine was congested, wherefore Kocher recommended that more or less of this be excised, and then it should be emptied by mild pressure and its dilatation diminished by astringent injections. Dr. Verneuil claimed that Dr. Perier had himself made the best criticism on this operation; he had allowed a spachelated sac to remain in contact with the intestinal walls, serosities being rich in bacteria. He wished to know if in these cases operating for artificial anus was not indicated. He believed that in such cases as this the artificial anus was indicated rather than enterorrhaphy, it having hitherto given good results. Dr. Perier said that if he had to do this operation again he would use the interrupted suture. He had on this occasion taken the precaution to include in the suture only the serous and muscular tunics. As to the advantages of artificial anus, that was a question to be settled. Dr. Desfres, in examining the alleged gangrenous portion, had not incised it; had he done so, he would not have doubted the existence of gangrene.—*Chicago Medical Review*.

EXCISION OF PART OF THE STOMACH.

BILLROTH has recently (*Wiener medicinische Wochenschrift*, February 5, 1881), reported the following case: A patient, forty-three years of age, was attacked by symptoms of pyloric cancer in October, 1880. A tumor about the size of a moderately-sized apple lay on the upper side of the stomach, somewhat to the right. Owing to rapid emaciation operative procedure was determined on and agreed to by the patient. A transverse incision, three and one-fifth inches in length, was made through the walls of the abdomen over the tumor, which was found to be a partly knotty infiltrated cancer, covering the pylorus and a little over a third of the under part of the stomach. Dr. Billroth loosened the adhesions of the omentum, separated carefully the greater and lesser omentum, and tied all the blood vessels before cutting

them through, the resulting loss of blood being but slight. An incision was then made through the stomach about a little over one-third of an inch beyond the infiltrated part, at first in a backward direction only, and afterward through the duodenum. Through the lips of the wound six sutures were passed, the threads being only used to keep the lips of the wound in apposition, and being left untied. A further oblique incision was then made into the stomach from within and above in an outward and downward direction, keeping always a little over one-third of an inch from the infiltrated part of the wall of the stomach, and then closed this oblique wound from below upwards, until an aperture was left just of sufficient size to fix the opening of the duodenum. The separation of the tumor from the duodenum was made by incision parallel to that of the stomach, always at the same distance from the infiltrated part. The duodenum was then introduced into the opening of the stomach, which had been left. There were about fifty sutures made with carbolized silk. The wound was washed with dilute carbolic acid; the whole replaced in the abdomen and the abdominal wound closed and bandaged. There was no pain or vomiting subsequent to the operation, which lasted an hour and a half. Ice only was given by the mouth during the next twenty-four hours, with nutritive enemata. The patient slept well after a small dose of morphia. The excised portion was about five and a half inches in length along the greater curve of the stomach. The seventh day after the operation the wounds were doing well, the general condition of the patient was good, she being able to take broth, eggs and coffee without distress. The case is the second on record, Pean of Paris having performed a similar operation.—*Chicago Medical Review*.

STRETCHING OF THE SCIATIC NERVE.

BROWN-SEQUARD (*Gazette des Hopitaux*) has performed this, on healthy animals and on those in whom a lateral hemisection of the cord had been made. In the latter the anæ-

thesia of the side opposite to the hemisection of the cord disappeared after elongation of the sciatic nerve. In a certain number the anæsthesia has been even replaced by hyperæsthesia. Voluntary motion was sensibly affected in the member whose sciatic nerve had been subjected to elongation; in certain cases there was even an almost complete paralysis. In animals whose spinal cord had not been operated on, Brown-Sequard found that stretching of the sciatic nerve also produced hyperæsthesia, but in a lesser degree than in the animals whose spinal cord had been cut, and that in opposition to what occurred in these last, no paralysis resulted. Laborde, after having cut the spinal cord of a peacock, stretched one of the sciatic nerves and found that on pinching the claw of the opposite side, epileptoid convulsions resulted. In a healthy animal the stretching of the nerve resulted in a pretty nearly complete loss of sensation on the corresponding side. Motion is preserved in both members. Laborde concludes that nerve-stretching leads to modifications in the structure of the nerve which prevent the sensory impulses from passing, but have no effect on the motor.—*Chicago Medical Review*. •

ALUMNI MEETING.

THE second annual meeting of the Alumni Association of Bennett Medical College occurred Tuesday, March 22, at the College Building. Recent heavy snows had so seriously obstructed railway travel that members from a distance were unable to be in attendance. The meeting was consequently small in numbers. About twenty old members were present, and the same number of new ones were received from the last graduating class. The morning session was devoted to the transaction of business, and the afternoon to class and college reminiscences, which were of an exceedingly interesting nature.

The following is the list of officers for the ensuing year:—

President—Finley Ellingwood, Manteno, Illinois.

Vice-Presidents—E. F. Rush, Chicago, Illinois; F. W. Rhor.

Kenosha, Wisconsin; C. J. Cook, New Providence, Iowa; E. M. Conklin, Tecumseh, Michigan; C. S. Stoddard, Redwood Falls, Minnesota.

Secretary and Treasurer—W. K. Harrison, Chicago, Ill.

Executive Committee—W. K. Harrison, Mrs. H. K. Whitford, Elgin, Ill.; N. H. Paaren, Chicago, Ill.

Board of Censors—H. S. Tucker, Otilie Ricklefs, Carl Giegerich, Chicago, Ill.

A SUCCESSFUL CASE OF TRANSPLANTATION OF SKIN, ACCORDING TO WOLFE'S METHOD.

BY EDWARD T. ELY, M.D., NEW YORK.

It seems desirable to record the successful results of skin-grafting, according to Wolfe's method, and I can add one to those already reported by Wolfe, Wadsworth, Noyes, Matthewson, Howe, Zehender, and Aub.

My patient was a man aged fifty, whose face and eyes had been burned in a powder explosion. The right eye was lost. In the left eye the lower conjunctival cul-de-sac was obliterated, and the lower eyelid (which was cicatricial) was adherent to the globe so as to cover most of the cornea. Through the narrow strip of cornea which remained free the patient had good perception of light when the pupil was dilated with atropine.

On September 30, 1880, the lid was separated from the globe, so as to restore the normal space. A piece of skin a little more than an inch long and three-fourths of an inch wide was taken from the patient's forearm. It was applied to the raw, inner surface of the lid, and a few sutures were used to aid in keeping it in place. The dressing was cotton and a bandage. The graft united by first intention along the edge of the lid, and no sloughing occurred, except of a small point at one end. A thin superficial pellicle was exfoliated from the entire outer surface. The sutures were removed October 5th and 6th. I was unable to prevent the lower edge of the graft from being gradually crowded upward in the

subsequent cicatrization, so that the final result was to enlarge the exposed portion of cornea by only a small area, and this has never become clear enough to be of much use. The patient's eye is more comfortable, but he has not vision enough to go about alone. An upward iridectomy may improve it. But, so far as the vitality of the graft is concerned, the success was very gratifying. No antiseptic precautions were used, and in holding the skin over the end of my finger to scrape off the fat and cellular tissue, it was rather roughly handled, and dropped twice upon the floor.

I have employed this method once in operating for ectropion, and the graft (which was larger than the one described above) sloughed almost entirely. The patient was a very young boy, who could not be kept quiet or be prevented from crying after the operation.

In the case of a woman with symblepharon in Charity Hospital, I operated by transplanting a piece of conjunctiva, about half an inch square, from a man's eye affected with panophthalmitis. The graft lived. I thought that the hyperæmic condition of the transplanted conjunctiva was perhaps a favorable influence. The result for the symblepharon was only partially successful.—*Medical Record*.

THE IDEAL TEACHER OF PATHOLOGY.

IF anatomy and physiology constitute the introduction to the general study of medicine, pathology may be considered as the immediate introduction to its practical fields. It is the great connecting link between the strictly theoretical branches on the one hand, and clinical medicine and surgery on the other. He who does his duty as a teacher in this important field will be rewarded by seeing his pupils become good diagnosticians and rational therapeutists hereafter; he who fails to do his duty will be responsible for the degeneration to routine mediocrity of those unfortunate enough to fall to his charge. In no branch of medical education is reform so necessary in American schools as here. Have not many of our readers been under the instructions of teachers who had

never made a single microscopical preparation in their lives, who could not point out the character of such preparations as might be brought to their attention by others, who never illustrated their lectures by means of autopsies, who had no adequate idea of the normal anatomy of the organs they were supposed to demonstrate the morbid changes of, and whose instructions consisted in a series of confused readings of manuscript, the gaps in whose originality had been filled in with liberal quotations from defunct works like Greene, or translated compilations like Wagner—Uhl? Are there not such lectures on pathology in our medical schools to this very day?

Instruction in pathology should be conducted on a plan similar to that announced in previous issues of the *Review*, as most advantageous for the anatomist and physiologist to follow. The teacher of pathology should begin with the tangible and concrete. Of one-sided drudges, who have amused themselves with making sections and staining them with the various cosmetics of histology, we have no dearth. There are such whose ambition in life is to invent a new staining process—borax-carminé pathologists; there are those who have gone mad on photography, but who, like the pathologists of the Utica asylum, when it comes to generalizing and interpreting results, are compelled to negotiate a loan from Rindfleisch or some other fundamental author. These are comparable to loiterers by the way-side who pick up the instruments of a science and treat them as immature minds naturally are compelled to treat them, as toys! When to such falls the task of instructing, is it to be wondered that they overburden the minds and destroy the enthusiasm of their pupils by the dull, parrot-like repetition of unassimilated details? We have known one such whose every fourth word was “cell,” and it may be imagined to what punning cognomen this fact gave origin among his students, especially when at the close of every introductory paragraph, the same luminary stated of the several structures of which he was treating, “what their function is we of course don’t know.”

Just as naked eye anatomy should precede the study of microscopical anatomy, so should the examination of coarse pathological changes precede the analysis of finer histological alterations, however these may lie at the basis of the former. There are many who have heard much about the minute structure of granulations, who are not familiar with the vastly more important naked-eye appearance characterizing the different varieties so important to recognize in practice. Hyperæmia and anæmia of the various organs, abscesses in various stages of formation and situation, the pyogenic membrane, the infarction, the thrombus, necrosis, and gangrene, parenchymatous hæmorrhage, surface inflammation, false membranes, pylephlebitis, bronchiectasis, valvular lesions, pyonephrosis, hydronephrosis, hydrocephalus, and spina bifida, are all conditions patent to the naked eye, easy of recognition and admirably illustrative of many fundamental pathological principles. If the old servant at Rokitansky's laboratory could learn to recognize these conditions and valvular lesions almost as well, if not as well, as his master, although devoid of microscopical or any theoretical knowledge, is it not perfectly evident that with appearances so easily comprehended merely through the channel of observation, the beginning should be made.

Having familiarized his pupils with the ordinary naked-eye evidences of disease, found after death, the teacher's next step is to take up those which call into exercise the faculty of logical combination; associated lesions, visible to the naked eye, or necessitating at most the employment of the lower powers of the microscope. Such school-analyses, as they might be termed, are the study of hepatic cirrhosis with its associated disturbances of distant organs; certain cardiac lesions associated with hepatic changes; pyæmia, and the multiple metastasis of certain new formations. Here the influence of cause and effect is visible without the aid of complicated or theoretical reasoning, and the student has now received that preliminary insight into pathology which will facilitate the intelligent appreciation of the purpose of the more elaborate inquiries which are to follow.

Instruction in pathology has another great analogy with anatomy and physiology. Just as the anatomist begins with the simple organism, the ovum, and the physiologist with the amoeba, so the pathologist opens the systematic development of his subject, which is in order as soon as the preliminaries just mentioned have been gone through, with a consideration of the embryonic connective tissue cell. This little organism, with its numberless metamorphoses, is the ground work of modern pathological anatomy. No course on this subject is complete unless it includes a disquisition on the middle-germ layer of the embryo, and the different tissues which are developed from the originally indifferent mesoblast cell. When the student has been shown how a cell resembling the ordinary leucocyte may in the course of normal embryonic development become a lymphoid cell, a glandular element, a muscular cell, a vascular wall cell, a large or small, spindle-shaped, pigmented or unpigmented connective tissue cell cartilage, bone or mucoid tissue, he will be ready to comprehend the multitudinous forms of morbid growths and inflammatory neoplasia which otherwise would represent in his mind so many unmeaning names. He has classified and defined in his mind the lymphoma, adenoma, myoma, cavernous growths, carcinoma, sarcoma, with its small and large celled melanoid and cystic varieties, enchondroma, [myxoma, and the minute structure of pseudo-membranes and sclerosed tissues.

It is at this point that the ideal teacher of pathology will lay the greatest stress on the fact that one-sidedness is the greatest drawback to a practical utilization of pathology, and that an accurate knowledge of microscopic changes is not the sole thing needful, for nine times out of ten the diagnosis of a tumor during life has to be made by methods not microscopical in character. The older method of diagnosing tumors on the strength of certain characters obtained through empirical methods, has been thrown overboard by certain of our younger microscopical enthusiasts, and it cannot be said that what the latter have offered us in place, at

all satisfactorily fills the demand. The microscopical criteria adopted by various instigators of such fundamentally distinct tumor groups as the spindle sarcoma and the carcinoma are not at all uniform; a pathologist of some repute not very long ago affirmed an inflamed, suppurating and somewhat tumefied bone to be the seat of an osteo-sarcoma, and it would not be difficult to select specimens of a similar character so as to mislead many who devote considerable attention to these subjects, into the commission of equally grave and absurd errors. The teacher who will honestly state how far the microscopic methods of diagnosis are absolute and how far still uncertain, necessitating the collateral study with the naked eye does his pupils a far greater service than he whom one might be in doubt whether to consider an extreme enthusiast, or a devotee of charlatanry, who, after a microscopic examination of the blood, tells his patient whether he can marry or no, and how long he will live.

These are the main cautions which the teacher of pathology should obey. That he should, in addition to a thorough knowledge of normal anatomy, physiology, embryology, and the fundamental facts of medical chemistry, be a master of the dissecting art, the use of the microscope, and possess a fair knowledge of those lower forms of animal and vegetable life which interest the physician in the shape of parasites, is so evident that we need but enumerate these conditions.

The one great lesson to be inculcated to the teachers of the three fundamental medical branches, treated of in this series, is that it is better to teach a fundamental fact well, than a fine point without the fundamental fact. The anatomist who teaches his pupil the valvular mechanism of the heart without the histology of the endocardium, is worth ten anatomists who dilate on the histology of the endocardium and fail to render clear the valvular mechanism. The physiologist who properly conveys the mechanism of the chyle circulation to his class, although he omit the minute chemical composition of that fluid, does that class an actual service, while the windy medical journalist who "professes" physiology in a

certain veterinary college, and teaches that the thoracic duct empties into the heart, is a biped detriment, notwithstanding the elaborate table copied from Gorup-Besanez, which he reads off to his bewildered victims. In like manner the pathologist who demonstrates the naked-eye evidences of atheroma, ignoring the subtler changes of the capillaries, is a useful member of the profession, and much to be preferred to him who, after a short sojourn at a European laboratory, graduates into a special pathologist of some sectarian hospital on his return, and writing elaborately on such stupendous topics as the histology of the lachrymal sac, or of parotitis, exhibits the normally present choroid plexus of the fourth ventricle, as a syphilitic neoplasm to the hospital staff.

Clearness and balance are the first requisites of the teachers of these as of all other branches of science. The intricacy of a subject is no warrant for one-sidedness or obscurity on the part of the teacher.—*Chicago Medical Review*.

OVARIAN CYST.

A Case in Practice—Ovariectomy—The Operation Successful.

BY PROF. E. YOUNKIN, M. D.

IN May last, I received a letter from Mrs. C. C. Graham, of Abingdon, Illinois, with the following statement: "I have been sick for nearly two years with what Drs. R. and P. call dropsy; I suppose dropsy of the abdomen. I have a hurting below, and at the left of the pit of the stomach; the abdomen is enlarged, tense and hard. There is soreness across the lower part of my abdomen. My back is weak and my urine scant and high-colored. My appetite is poor and my stomach is often sour. My age is fifty-four years, and I thought that I had passed the change of life about two and a half years ago, but for the last two months I have had an almost constant menstrual discharge, which at times is pale and at other times quite dark. I have taken the comp. powder of jalap and senna, cream of tartar, mandrake, elder, Indian hemp and elaterium, until I can take them no longer, on ac-

count of the severe action and pain they produce. I do not expect you will give me much encouragement, but having known you so long, and in former years you having been our family physician, I am anxious to have your opinion in my case."

As intimated, I had been acquainted with Mrs. G. in former years. She was the mother of four children; about medium stature, dark complexion, black hair. Having practiced my profession alongside of Drs. R. and P. in former years, I stated in reply that these gentlemen were intelligent men, and it was reasonable to suppose that they, having a personal examination of her case, could tell more about it than I, as I could only judge from the brief array of symptoms given in her letter, but it was my opinion that she had an ovarian tumor.

On my way to the National Eclectic Medical Convention, which met in Chicago in June last, I was requested to call that way and make an examination. I did so, and found unmistakable evidences of an ovarian cyst. The fluctuation was more indistinct than in ascites, the walls of the abdomen moved over the walls of the cyst and could be distinctly felt. The enlargement had begun in the left ovarian region, and as it grew it extended to the right side and higher up in the abdomen. The general health was better than what we might expect in ascites. I told her plainly that the only real hope of cure consisted in an operation—ovariotomy, and this was attended with great risk, but, as she was, death was inevitable at no far distant period. As a temporary relief from the pressure, I thought it best to tap the cyst and draw off the fluids, and by the time it filled again she would have time to consider the matter and make up her mind as to what course she would prefer. I introduced the common trochar and canula one inch below the umbilicus and drew off two patent buckets full of brown fluid, thus producing an entire collapse of the cyst. I prescribed fluid ext. apocynum, ten drops to be taken three times a day, with the hope of hastening the fluids of the body through the kidneys and bowels.

This produced the effects mentioned, but withal the cyst soon began to fill. In the course of a short time the quantity of the above drug produced too active a catharsis and some nausea, and the dose was lessened. Tinct. ferri mur, and cinchonidia were given to husband the strength.

This woman is intelligent. Her father was a physician, and she had studied Beech and Morrow, until, in the absence of a reformed physician, she assumed the task of treating the members of her own family.

The diagnosis of an ovarian cyst being made, a new field of investigation was opened to her view, and aside from the sea of questions propounded to me she set herself about to investigate the literature upon this subject. I felt it my duty to aid her in her investigations and to answer every question with fairness, and then let her draw her own conclusions as to the course to pursue in the matter.

Questions and Answers.—The following are some of the interrogatories propounded by the patient during the period of investigation.

Ques. 1.—Are you sure if I recover from the operation that it will not return again.

Ans.—Ovarian cysts belong to the class of innocent tumors; they are not likely to return, but the other ovary may be diseased and grow in after life. If the tumor is of a cancerous or fibrous character it is very likely to recur. Yours, however, is of the innocent class, and creates its disturbance mainly by its bulk.

Ques. 2.—Do you regard my case as one of many complications? In other words, is not my stomach, liver or kidneys so diseased as to make the case more hazardous?

Ans.—I do not regard your case as presenting unusual complications. Your stomach, liver and kidneys are oppressed more from the burthen of weight and pressure than otherwise, and I believe if you recover from the operation you will be comparatively healthy.

Ques. 3.—I fear that the cyst has grown fast in some places. Does not this take place sometimes?

Ans.—Yes. Your cyst is quite large, and I expect some adhesions to the walls of the abdomen or omentum. Where they are not too extensive they are taken off and patients recover. If too extensive they might cause the operator to desist before completing the operation. In a case in this city, the uterus, all its posterior wall and the fallopian tubes were adherent to the cyst and drawn up to the umbilicus, besides other adhesions to the abdominal walls and omentum. They were all taken off and the patient made a good recovery.

Ques. 4.—Have I only one cyst?

Ans.—Yes. This question is definitely settled, since we tapped only in one place and produced a complete collapse of the enlargement.

Ques. 5.—If I should have the operation performed and should recover, what length of time will I have to lie in bed?

Ans.—You should be on your feet in about three weeks.

Ques. 6.—From what you know of my case, do you think mine is as favorable as the others you have operated on who have recovered.

Ans.—Yes. I know of nothing that will particularly interfere.

Ques. 7.—What are the general results or per cent. of ovariectomy cases?

Ans.—Spencer Wells in five hundred cases of ovariectomy had three hundred and seventy-two recoveries and one hundred and twenty-eight deaths; a per cent. of 74.4. In one hundred cases operated on by Keith, eighty-four recovered, and still later this surgeon announces ninety-six per cent. under the antiseptic spray. Shroeder in fifty cases had ten deaths, eighty per cent. of recovery. Thirty-three of these were operated on in the Berlin Hospital—a place notoriously bad in its sanitary appointments. These were performed under the antiseptic spray, and there was but the loss of one. It is difficult to determine the average per cent. of the operations of ovariectomy performed by all the surgeons, but I think we may safely conclude that the recoveries do not exceed $66\frac{2}{3}$ per cent.

Ques. 8.—Will you give ether or chloroform? Is ether dangerous? I do not want to take chloroform.

Ans.—I prefer amyliated chloroform. This keeps the blood circulating through the brain, and, I believe, does away to a great extent, the danger we once had in the administration of chloroform alone. I do not like ether so well. It is more likely to sicken the stomach, and the patient, not so profoundly asleep, is liable to suffer from the shock of the operation. All anæsthetics are attended with more or less danger. I select chemically pure chloroform, and to six ounces add from twenty to thirty drops of nitrate of amyl.

January 20th I received a letter stating that my patient had about concluded to undergo the operation—that I might set the time and come at my earliest convenience. “If, after an examination,” I thought it best to operate, she would “*try* and muster up courage enough to proceed.”

I thought this conclusion too equivocal, and wrote in reply that before I could consent to make a distance of 160 miles, I must have an unequivocal answer to two questions. First, have you fully made up your mind to risk the operation? Second, what time shall I come? The first one of these you must answer yes, or no, as I alone must be the one to decide when I come. The second you should decide, giving at least ten days to make preparations. These were now answered promptly, and February the 15th was set for the day.

Preparatory.—My patient had of her own accord been dieting all the winter, thinking by this to produce some effect on the tumor. I ordered her now to eat light and digestible food; to take a bath every other day; to prepare her clothing in a way to be changed readily without the fatigue of rising up; to select an apartment, large, light, easily ventilated and free from all unnecessary furniture. The bed to be prepared in a simple manner,—a new mattress and at most a small feather bed. A thermometer in the room, and facilities for keeping the temperature at 65° Fahrenheit. To select intelligent and careful female attendants, and that it would be desirable to record the morning and evening tempe-

rature for four previous days. Upon the morning of the day previous to the operation take castor oil enough to produce two or three evacuations. Upon the previous evening take salicylate of soda, gr. v., and repeat this the next morning. Early in the morning of the operation take only as food a bowl of beef tea; at ten o'clock unload the rectum by an enema of warm water.

February the 15th found me at the hotel in the little city of Abingdon. Dr. J. H. Tilden, our rising professor of anatomy, and Dr. A. W. Foreman of Whitehall, Ill, accompanied me and gave valuable service. The morning sun arose in splendor and spread its golden glory over the little cottage of my patient, which is situated at the foot of the college wherein I had spent my student life. The earth was white with the beautiful snow, and the gently wafting breeze seemed to whisper an encouragement to my ear. It was widely known that this was the day for the operation, and the numerous sympathizing friends with the gates of heaven ajar were supplicating a successful issue. Feeling that the prayers of the righteous availeth much, I too, trusted in God and trimmed my armamentarium. An invitation was extended to the physicians of the town, and when the hour arrived there were present Dr. J. H. Tilden of St. Louis; Dr. A. W. Foreman of Whitehall; Dr. Cater of Macomb; Drs. Heller, Miller, Rowe and Belwood of Abingdon. It is worthy of remark that the above list of physicians were composed of the three different schools, Eclectic, Allopathic and Homeopathic. These were most pleasantly associated by a liberality which lurks within my bones:

How pleasantly to behold and see
The friends of *Æsculapius* all agree.

Aside from these, the patient had selected a half dozen of the best women of the place. No surgical operation was ever *womened* with a more sturdy, self-sacrificing and pains-taking class of female assistants.

Operation.—At 11:30 o'clock, with a cloud of carbolic acid spray (one-fortieth per cent) falling upon her abdomen from

the instrument of Codman and Shurtleff, the necessary incision in the linea alba, below the umbilicus, was made, and with a few snips of the knife the peritoneum was reached. With a pair of toothed forceps this membrane was pinched up and a small opening made through it, at the lower part of the incision, sufficient for the introduction of a director, which was then introduced and served as a guide and protector in cutting.

After the peritoneum was opened a bluish and shining sac presented, jugged over with peritoneal adhesions, and so firm were these that for a moment it was a question in my mind as to whether I had as yet penetrated the peritoneum, but a moment's manipulation convinced me that it was the walls of the cyst. Owing to the extensive adhesions in the whole course of the incision, the enormous size of the tumor, and the difficulty of manipulation the incision was now extended upwards around the left of the umbilicus to about one inch above it, then, at the other extremity of the incision, down to near the symphysis pubis. The adhesions were then torn, separated with the fingers and handle of the scalpel; the thickest of them ligated with carbolized catgut. There were seven or eight of these ligatures which were cut short and allowed to remain within the abdomen. There was but one or two omental adhesions, which were low down upon the right side. As many adhesions as conveniently laid within our reach were thus severed, after which a wash tub was moved up to the side of the table and the cyst tapped with the trochar of Spencer Wells. The whole mass was now so reduced that it could be easily drawn out of the abdomen. It proved to be the left ovary as diagnosed. The pedicle was now tied by one strand of fine silver wire, the ends of which were twisted upon each other, then rolled into a ball the size of a bird shot, so as to conceal the ends of the wire. The pedicle was cut, and with a small sponge, saturated with pure carbolic acid, the stump touched to whiteness, then dropped into the abdomen. There was but little loss of blood. The omentum lay between the tumor and intestines, and the

intestines were not disturbed. Care was taken to wipe out the abdominal and pelvic cavities. The water used in the sponging, and that also in the spray, was distilled. All the distilled water was carbolized. Two gallons is necessary for an operation. Every physician who expects to assist about the incision must bathe his hands in carbolized water; every instrument used is thus previously bathed. Special care is taken to keep the walls of the abdomen moistened with the acid cloud; the walls of the abdomen are for a few moments held up to receive within the cavity of the abdomen the spray.

The wound was now closed with silver wire sutures about an inch apart. The sutures were set three-fourths of an inch from the incision, passing directly through the skin and peritoneum, the wound drawn together with a firm support, but not so tightly as to compress the circulation within the sutures. Gaping places between the wire sutures were secured by superficial silken sutures. The abdomen was dressed. First, a layer of carbolized gauze, held for a few moments over the spray, then placed directly upon the wound; over this a layer of absorbent cotton; upon this a piece of antiseptic silk; now a piece of Seabury and Johnson's rubber tissue, cut the whole size of the abdomen and placed over all; an abdominal bandage encircling the body, secured the walls of the abdomen and dressings. The rubber tissue, receiving the warmth and moisture set itself closely to the skin upon the abdomen and thus all was hermetically sealed. One quarter of a grain of morphia was now administered hypodermically—the patient removed to her bed and allowed to return to consciousness. Hot applications were placed to the feet and two lady assistants placed by the bedside to guard unnecessary struggling.

I never saw a patient stand an anæsthetic better. No excitement, no nausea, either in going in or coming out. No pallidity nor bad effect in any form. Duration of the operation—one hour and twenty minutes. The tumor weighed forty pounds.

After Treatment.—The patient rested well the balance of

the day and following night. The urine was drawn every six hours. No stimulants, food, nor medicine was given until

February 16.—This morning the dressings were changed to get away what little bloody exudation was absorbed into the gauze and cotton. There is no pain nor tympanitis. Temperature, $100\frac{1}{4}$; pulse, 85. Gave, *R.* Tinct. aconite rad., gtt. x; baptisia fld. ext., gtt. xxx; aquæ, pure, $\frac{3}{4}$ iv. *M.* A teaspoonful to be taken every two hours. This was done to forestall the rise of temperature and meet any septic change that might follow. Temperature in the evening, 100; pulse, 83. Gave morphia $\frac{1}{8}$ gr. hypodermically and continued aconite and baptisia through the night.

February 17.—Patient rested well through the night. Temperature, 98.5; pulse, 80. I am persuaded that this normal standard of the temperature and the pulse is due to the aconite. I withdraw its use for the time being. She asks for something to eat. I now prepare: *R.* Horlick's food, one tablespoonful; dissolve this in four tablespoonfuls of hot water and add an equal quantity of fresh milk. Of this, two tablespoonfuls to be taken every three hours. The temperature rises in the evening to 101; pulse, 96. I returned to the aconite and baptisia. A dose every two hours through the night, and $\frac{1}{8}$ gr. morphia hypodermically in the evening.

February 18.—Had a good night's rest. Morning, temperature 99. Says that if she could have her way this morning she would take tea, Graham gems, and hash. She takes Horlick's food with a relish. I took out the superficial stitches. Parts look well; no swelling or tympanitis. Evening, temperature 100. I believe she will rest without the morphia. Withdraw every agent.

February 19.—Felt a little restless toward morning, but better now. Takes half a teacup of Horlick's food. Temperature in morning, 100. One-half the wire sutures are now taken out. Parts seem united except around the umbilicus and at the lower part of the incision. Sutures at these points left remaining. Up to this time the menstrual flow, which had been upon her incessantly for two months, had continued.

It has now ceased. It has been the result of pressure. Evening, temperature 100.5. Began the aconite again.

February 20.—Pulse this morning 86, temp. $98\frac{3}{4}$; feels comfortable; talks and laughs with her friends; takes Horlick's food and nothing else.

February 21.—This morning the temp. is normal, pulse 80. I took out the remaining sutures; slight redness around the umbilical incision and the dressing slightly bathed with pus at the lower part of the wound, but all doing well. I now left my patient in the care of her husband, who had carefully watched the method of dressing, and had learned to use the catheter. Directing them to guard the case and report, and if anything went wrong to call a physician of the town.

February 24.—(Report from her husband by letter.) "As far as I can see Mrs. G. is doing nicely. We began to give her a little gruel for a change. She has some pain in the lower part of her bowels. They have not moved since the operation. We relieve the pain with warm cloths. The sore is doing well; has a very little matter at the lower part. Her appetite is good. Changed position a little this morning. We have quit using the catheter, and use the bed-pan instead. What course shall I pursue?"

I answered, give an enema of warm water and castile soap and follow up the old plan.

February 26.—Mrs. G. was very restless night before last. She had fever and pain in her bowels. When we received your letter we gave the injection, which relieved her immediately, and now she is like another woman. She has been braced up twice in bed and feels rested.

February 28.—Your patient is doing splendid. Set up an hour yesterday and an hour to-day. Appetite good. No pain nor fever.

March 2.—Mrs. G. is eating and sleeping well, and has no fever. She has walked to the stove yesterday and to-day, and sits up over an hour at a time.—*American Medical Journal.*

NOTES OF THE SURGICAL HISTORY OF THE
LATE WAR.*Gunshot Flesh-Wounds of the Abdomen.*

BY C. M. BRUCKER, M. D.

Gangrene.—Sloughing was an infrequent, but dangerous complication; supervening oftenest in shot lacerations produced by shell fragments or by elongated balls striking sideways. These sloughing wounds, by leading to secondary hemorrhages, septicemia, exhaustive suppuration, and consecutive peritonitis, increased the mortality list of gunshot flesh-wounds of the abdomen.

Hernia.—Ventral was a frequent result of incised, lacerated, and shot wounds of the abdominal wall, and an occasional consequence of contusions, followed by muscular atrophy. Inguinal hernia was often ascribed to these causes. Great liability of men of the military age and stature to hernia is observed even in classes of recruits selected after the most rigorous physical examination; and, naturally, the proportion of ruptured men was greatly augmented when, during the war, the recruiting regulations were either relaxed or systematically disregarded. Soldiers laboring under this infirmity rarely failed to recall some blow or muscular strain which connected their infirmity with the incidents of service; and a wound of the abdominal walls was adduced by a ruptured applicant for discharge as an unquestionable cause of, perhaps, a scrotal hernia. On the other hand, direct ventral hernia was an almost uniform and necessary consequence of extensive injury of the muscular walls.

Nervous Disorders.—Profound shock was often caused by simple contusion of the parietes, and also by shot contusions and flesh-wounds; but it was not common in the absence of visceral lesions. Tympanitis and constipation following contusions and wounds of this region, in which there was temporary paralysis of the muscular coat of the bowels, were ascribed to concussion of the nerve centers. Persistency of collapse appears to have been indicative of internal lesion, but

the nature of the case could not be determined by the intensity of the symptoms as a standard. Twenty cases appear on record in which partial paralysis in one or both of the lower extremities was attributed to shot wounds of the parietes. An examination of the details of these cases on hospital and pension reports indicates that the loss of motor power was due, in most instances, to contracted cicatrices or to muscular atrophy, and that only those in which some injury to the spine might be suspected were examples of true paralysis. Among the punctured wounds there were no instances of that local irritation of the nerve filaments to which Boyer especially calls attention in his work, and who also states that this local nervous irritation can best be relieved by introducing a caustic troche into the wound.

Tetanus.—No instances are recorded of the appearance of tetanus in the punctured and miscellaneous wounds of the parietes, but eleven cases are recorded among the gunshot flesh-wounds of this region. Ten of these, well developed, terminated fatally; the eleventh, described as an example of "slight trismus, with tetanic symptoms," terminated favorably. The cases in which tetanus complicated penetrating wounds of the abdomen and superficial and deep wounds of the pelvis, are more numerous than those in which tetanus was complicated with injuries of the chest.

The survey of the cases of injuries to the abdominal walls indicates the proportion of instances in which troublesome complications arise—the necessity of enlarging wounds to control hemorrhage, to remove foreign bodies, or to prevent the confinement of pus; the necessity of promoting cicatrization by position, bandaging, and sometimes by sutures, and of averting peritonitis by quietude and the use of opium.—*Medical Investigator.*

SYPHILIS AS A CAUSE OF LOCOMOTOR ATAXY.

IN 1878, in a paper read at the Bath meeting of the British Medical Association, Dr. Gowers expressed the opinion

that syphilis must be regarded as the cause of locomotor ataxy in one-half the cases of that disease. Since then the subject has received much attention from the hands of Erb, Westphal, Remak, and others. In the *Lancet*, January 15, 1881, Dr. Gowers offers thirty-three cases of the disease in men as some evidence in support of his assertion, made in 1878. Of this number twenty-three (about seventy per cent) had suffered either from a primary sore or secondary symptoms, and in fifty-three per cent there had been undoubted constitutional symptoms, of which, in several, the indications were still present. The significance of these facts depends on the proportion of the male population of the country who have had primary sores, or constitutional syphilis. Before assuming a causal relationship in these cases between the antecedent venereal disease and the subsequent locomotor ataxy, we ought to deduct from the coincidences that proportion which the prevalence of venereal disease may have rendered accidental. Unfortunately, we have not the necessary information; but it is probable that the proportion of adult males, over twenty-five, who have had venereal sores, or symptoms of constitutional syphilis, is much smaller among the middle classes than among the poor. It is therefore of interest to inquire whether syphilis precedes ataxy with equal frequency in the two classes. Of the thirty-three cases, twenty-one were seen in hospital practice, and twelve in private. Of the former there was history of constitutional syphilis in ten, and of a venereal sore alone in five, making a total of two-thirds of the hospital cases. Of the twelve cases in private, there was a history of secondary syphilis in eight, and of a venereal sore alone in one, a total of three-fourths of the cases. These facts suggest that syphilis is an antecedent of ataxy, at least as frequently in the well-to-do classes as among the poor.

As a rule, the interval between the syphilis and the first symptom of the ataxy is considerable. It was noted by Erb in only seventeen cases. In five it was between two and five years; in eight between six and ten; in four between eleven and fourteen. In Gower's cases, the exact interval was, as a

rule, longer than in Erb's cases. No case of simple tabes was met with earlier than seven years after infection, the actual numbers being: at seven years, one; at nine, three; at ten, two; at thirteen, three; at fourteen, two; at fifteen, one; at seventeen, one; at twenty, three; at twenty-one, one; at twenty-five, one. Thus two-thirds of the cases occurred more than ten years after the primary disease.—*Medical Record*.

THE DANGER OF DOMESTIC REMEDIES IN THE EAR.

BY PROF. HENRY OLIN, M. D.

LIKE the cornea of the eye, the membrana tympani is a fibrous, inelastic tissue, and may be greatly injured by the application of the hundred and one remedies that are suggested by the ever-ready-to-do-something persons, and which often prove a great damage to the poor, suffering patient, though applied with good intent and with a view to relief. It is well known that poultices and remedies that have a tendency to maceration of a fibrous structure when in a state of inflammation, produce softening of the parts, and hasten the ulcerative process and breaking down of the tissue, thereby causing a more destructive disintegration than would be caused otherwise. Now, in view of this fact, I wish to enter my protest against the too general practice of parents and others, of applying remedies to the eye and ear that may, in many cases, produce serious results. For example, we will take a simple case of catarrhal inflammation of the middle ear, which, if properly treated, would pass off in a few days without serious results, but, if tampered with, may result in suppuration and destruction of the tympanic membrane. The domestic remedies used in such cases are glycerine, olive oil, laudanum, goose oil, fat pork, boiled onion, poultices of different kinds, steaming, blistering, and, last and least dangerous, blowing tobacco smoke in the ear.

The tympanic membrane being a fibrous tissue, and, in a healthy state, perfectly dry upon its external surface, is soon softened by the application of such remedies, and the suppu-

rative process upon the inside, greatly encouraged, soon yields to the maceration, from the mucus and pus within and the oils, poultices, etc., on the outside, and, after a few days, breaks down and sloughs out, leaving the ear without a protecting membrane to the delicate cavity of the tympanum. Hardly a day passes but some patient presents himself at my office with a suppurative catarrh of the middle ear; and inquiry generally reveals the fact that the patient has had treatment by the application of some of the remedies above mentioned, with the results before described.

It is time that the profession and the general public should awake to the fact that nothing done is better than something that is actually injurious, and that, no doubt, produces many cases of otorrhoea and chronic inflammation of the mastoid cells, which trouble the patient for years, and result, many times, in caries of the bones.

The physician, applying a poultice to the cornea in case of inflammation, would be deemed guilty of malpractice. Equally guilty is he who would apply a poultice to an ear in case of catarrhal inflammation of the cavity of the tympanum, yet this is done every day, and much harm is the result.

The treatment of such cases should be of such a character that destruction of the part would not be hastened by the remedy, and, if pus forms to such an extent that it does not escape through the Eustachian tube, a paracentesis should be performed at an early date, to allow the pus to escape through the tympanic membrane, thus preventing a breaking-down of that tissue, and immediately arresting the pain, and relieving the patient. To a practiced eye, the time to do this operation will readily be seen, and in many cases it will save from destruction an ear that would otherwise be destroyed by a suppurative process.

Some years ago, while practicing in the country, I was called to see a patient that had been treated for several days for neuralgia, and, on making an examination, I found a suppurative inflammation of the tympanic cavity, with the membrane pushing outward, and just ready to give way to the

tension from the accumulation of pus within. I immediately performed a paracentesis, and the pain at once subsided, and the patient fell into a sound sleep, the first for several days. The amount of pus that exudes from the drum cavity in such a case is quite astonishing, and immediate relief is its result. —*Chicago Medical Times.*

FOREIGN BODIES IN THE STOMACH.

REPORTED BY CHAS. L. DAYTON, M. D.

THE following case which came under my observation many years ago is exceptional, and of sufficient professional interest to be reported. It demonstrates that in gastric diseases there is great difficulty in forming a correct diagnosis, and also in reaching a reliable prognosis, the problem only yielding a satisfactory solution through a post-mortem examination.

Mr. S., aged 45, residing at Black Rock, for a period of six months had complained of gastric pain with nausea, and other symptoms of indigestion; he presented the appearance of one suffering with scirrhus of the stomach, or aggravated dyspepsia. Failing to secure relief after consulting several physicians, he consented to accompany me with a view to consult Prof. Austin Flint, senior, then residing in Buffalo. Prof. F. examined the patient thoroughly, and expressed the opinion that he would ultimately recover. Two days afterward the patient suddenly died. At the autopsy, in the presence of Drs. L. P. Dayton, Tobie and Beaman, the stomach was removed. It contained a tumblerful of prune pits; the pyloric orifice was so far occluded by the induration of the surrounding tissues that it admitted only the passage of a small catheter. About three inches from the pyloric orifice the stomach was perforated, probably through the influence of the prunes. His wife stated that he had not eaten prunes in five or six months, and could offer no explanation for his swallowing the pits.

The case is interesting on account of the presence of so large a quantity of foreign substances in the stomach, of the simi-

larity of symptoms to those usually occurring in ulceration and scirrhus, and of the obscurity often attending gastric and intestinal disease, which is cleared up only through the post-mortem examination.—*Buffalo Medical and Surgical Jour.*

DIPHTHERIA.

BY F. L. GERALD, M. D., HYDE PARK, MASS.

DURING the past few years, this disease has excited the public heart, for, when once within the fold of a family of children, no one knows when or where it will end. Diphtheria is evidently a constitutional disease. It is eminently epidemic in character, and rarely occurs sporadically. The formation of membranous exudation upon the lining membrane of the mouth and fauces is, in many respects, enveloped in obscurity. The diphtheritic symptoms are the local expression of a special morbid condition of the system, and the nature of the blood changes remain to be ascertained. In the incipient stage of the disease, in many cases, there is but little inflammation of the tonsils or neighboring parts, the exudation first showing itself upon the tonsils in the form of whitish-gray or ash-colored specks or patches, which gradually enlarge or spread until they meet and form one continuous membrane. At this stage of the disease, the constitution is not usually very much disturbed.

In many cases, the fever is slight, the pulse not very much accelerated, the temperature is but little above the normal standard, the skin is not very dry, deglutition is not impaired, and there is but little pain and swelling about the throat. In some cases, the above symptoms constitute the whole of the complaint, recovery taking place without serious consequences. In others, they are but the beginning of more alarming indications, some reaching the crisis after several days, while others dash on to a fatal termination in a few hours. It seems to rage among children that have every comfort that the human mind could desire, as well as those that do not have the wealth and comforts that others are blessed with. The fol-

lowing has been about my course of treatment, with considerable success. When I am called to a child that has the characteristic symptoms of diphtheria, I usually prescribe thus:—

R. Tinct. aconite rad, gtt. vi.

Tinct. phytolacca decandra (green root) gtt. xxx.

Aqua pura oz. iv.

Dose—A teaspoonful every hour.

R. Bichromate of potash, first decimal, one or two grains, or enough to color half a tumblerful of cold water a little yellow. Dose—A teaspoonful every hour in alternation with the aconite mixture. (The first decimal, or any strength wanted of the potash, can be procured at any homœopathic pharmacy.) Every two or three hours, I give from three to five grains of hyposulphite of soda in cold water or syrup of ginger. If the mucous membranes have a purple appearance, chlorate of potash, in the same doses as the soda, will answer better. For a gargle, I use the following: Make a strong decoction of sumach berries, and to every half-pint add two drachms of chlorate of potash. If the child is old enough, use it freely and thoroughly; if not, let the throat alone. For the past two years I have not applied anything to the throat with the brush or pencil, and I have certainly had better success. As long as there is any poison in the blood, just so long the false membrane will appear upon the tonsils and neighboring parts. The constitutional treatment must be kept up until all trace of the disease has passed away. The patient should inhale the vapor of lime from some open vessel in severe cases. As soon as convalescence begins to take place, tinct. ferri chl. should be given in proper doses three or four times daily in cold water. The patient should always rinse the mouth with a little soda water after each dose of iron. In many cases, even of a mild nature, partial paralysis will follow for a few weeks after all other symptoms of the disease have passed away. In such cases I give tinct. of nux vomica, gtt. v. or x. (according to the age of the child). Acid phosphoric dilut. one drachm, glycerina pura and aqua pura aa. two ounces.

Dose—Teaspoonful in cold water every four hours. Where the glands of the throat are much swollen, the application of tinct. of phytolacca, tinct. of veratrum viride and alcohol, equal parts, is perhaps as good as anything that can be used; keep a flannel wet with the lotion about the throat constantly. Where the skin is dry and hot, I direct the patient to have an alkaline sponge bath two or three times daily; but if the skin is cool and flabby, I use a weak muriatic acid bath.

The food must be light and nourishing, fresh cream and milk with brandy if needed, ice cream, fresh essence of beef, and in some cases large quantities of sweetened water and brandy. I have prescribed sulpho-carbolate of soda, also iodide of arsenic; yet I have had the best success with chlorate of potash, aconite and sulphite of soda, phytolacca, bichromate of potash, aconite and belladonna. Of course, these remedies are not all indicated in the same patient at the same time, each remedy having its pathological indications.—*Massachusetts Eclectic Medical Journal*.

HOW DOES MEDICINE CURE?

BY S. H. POTTER, M. D.

THAT cinchona and its compounds cure ague, as a rule, with exceptional cases, is one of the best established facts in therapeutics. But how it does so we do not know, and it is impossible that we can know until we attain some idea of the nature and mode of action of the ague poison. Even the existence of this poison is known to us only by its effects. These effects are the various forms of malarial fever, and as common in large districts throughout the temperate and torrid zones as any malady known to mankind.

The literature of malaria is extensive and interesting, the hypotheses are numerous, the discussions of the various theories have long been ingenious, able and exhaustive, without reaching any "specific" fact. Time and space will not permit even a synopsis of the various speculations upon the subject here. Suffice it to say that the latest theory (speculation) is to regard miasm or malarial poison as consisting of

minute organisms. Only two, however, of all the many investigators assume to have discovered anything tangible. Prof. Klebes and Signor Thommasi Crudeli assert that in a malarial district near Rome they detected shining ovoid spores belonging to the genus *Bacellus* existing in the soil of malarious places, and that they may be cultivated in animal bodies, and in which these spores breed fever, resulting in enlarged spleen; they having inoculated rabbits with liquids taken directly from malarious soil containing such spores and with the result named

Notwithstanding, the opponents of this new particulate theory have answered by the sensible question: If such shining ovoid spores as miasm were really detected in the fluids of malarial soil, why cannot, or have not other distinguished searchers after them detected and tested their specific poisonous nature? As heretofore, writers and teachers are not wanting who are ready disciples of any new speculation. A late writer in the *Lancet* (London) in support of this latest theory, says: "It must be borne in mind that the limit of the microscopic demonstration of such minute objects is not the mechanical power of the microscope, but the visual power of our eyes. An object may be magnified 30,000 times and be visible, and yet disappears from our vision when magnified 60,000 times. The object is there, but its image is so attenuated by the increased power of the microscope that our eyes no longer detect it. Prof. Tyndall has demonstrated that the atmosphere habitually teems with particles so minute that they cannot be detected by the highest power of the microscope, and that many of these particles are organized." Ergo, "We cannot fail to see that our inability to detect and demonstrate that malaria is particulate and organized is no proof that such may not be its nature."

When the writer entered the medical profession, it had long been a well settled fact that mercury had "a specific action" upon the liver; no respectable author, teacher, or practitioner doubted it at the hazard of his professional reputation. When Prof. Bennett of Edinburgh, after a long series of carefully and

well conducted experiments proved that mercury did not act "specially" upon the liver at all, and that the characteristic alvine discharges resulting from taking mercury were simply due to its chemical action, or affinity to fluids in the alimentary tract, the whole intelligent profession were amazed to find all the medicinal starch taken out of their very best settled and most favorite way of treating all hepatic derangements which they imagined complicated by far the greatest portion of human maladies. That shows how easy it is for our whole profession to be mistaken about the "specific" *modus operandi* of medicine in antidoting unknown disease poisons.

Nor is it strange that we yet know so very little of how medicine cures most diseases, since we do not yet understand some of the commonest and most prolific processes of physiological action. To illustrate, take the question: How are red-blood-corpuscles formed? In solving this problem about as many hypotheses have been obtained, as over the question of the nature of ague poison, and how quinine cures ague. It is not a little remarkable that the origin of the formed elements of the blood should still be a matter of speculation, and that physiology is incapable of replying to the question: How after large loss of blood is its restoration affected?

This generation of practitioners are hardly aware of the quantity of blood that was taken from patients in acute diseases by physicians and surgeons of the past age. If works written early in the present century are referred to, many surprising facts of this nature may be found. About fifty years ago, at my advent into the profession, I saw my first preceptor, Dr. Edson B. Carr, treat a case of acute gonorrheal ophthalmia in an athletic, freely-living man, from whom he took the surprising quantity of one hundred and fifty-two ounces of blood or nearly eight pints, by venesection, besides the application of thirty-five leeches in the short space of one week. That the athlete recovered perfect vision in due time does not justify such heroic treatment. I have cured similar cases as soon, since then, without taking any blood. In the cases of women, enormous losses of blood are often sustained

in menorrhagia, which are yet quickly restored under favorable circumstances. Rindfleisch has made an estimate of the rapidity with which the reproduction of new corpuscles must take place in ordinary intermenstrual periods in such cases, and calculates that half a centigramme of blood is produced every minute, which means that about one hundred and seventy-five millions of red-blood corpuscles are produced every minute. It seems extraordinary that no answer can be given to the questions how and where this enormous proliferation is effected. Passing over the various hypotheses which from time to time have been launched upon our profession, suffice it to mention the latest. In the blood of animals undergoing repair after large hemorrhages, an extraordinary number of hæmatoblasts or globulets may be seen. These rapidly enlarge in all directions, lose their granular aspect, and become hyaline, and finally assume the discoid form and the yellowish tint of the full-formed corpuscle. The hæmatids are on this view neither cells nor the descendants of cells, but may, like Topsy, be said to have simply "grewed." It would seem that the generation of the red corpuscles remains yet in a dark corner in physiology, and further research and observations are requisite.

The foregoing brief illustrations show how very little we really know the precise nature of the real causes of many well recognized diseases, nor the "specific" action in curing them beyond the apparent result, as we suppose, of their use. Another fact is also rendered obvious, that physiology and therapeutics yet require further investigations in very many directions before medicine can arise to the dignity of an exact science. The general tendency in most cases of disease is to recovery, hence, however much we may pride ourselves over our cures, they, doubtless, are in most cases due more to good sanitation and the tendency of nature than to what we otherwise do. The more eminent authors, teachers and practitioners are modest about claiming undue skill, avoid hobbies of all kinds as much as possible, try to be satisfied with fair general success in following out the indications apparent, with the

safest and most sensible means and measures at their command.

Channing made this entry in his diary: "I wish to have a few important truths impressed deeply on my mind rather than to be lost in the chaos of universal knowledge which has hitherto distracted me." I apprehend that most readers will appreciate Channing's perplexity and not try to grasp too much; devote their entire powers of mind and body to their chosen profession in an unassuming and legitimate manner, and with an abiding and cheerful hope of success.—*American Medical Journal*.

Obstruction of the Bowels Caused by Large Worms.

IN the London *Lancet* for December 4, 1880, Dr. E. Downes has reported a case of intestinal obstruction caused by large worms. The patient complaining of constipation, purgatives were administered several times, but without avail. There was no indication of internal hernia. The abdomen was very much distended, and some coils of the intestines could be seen and felt pretty plainly through the abdominal walls. After a brief consultation it was agreed to perform Amussat's operation. Accordingly an incision four inches long was made about two inches above the crest of the ilium on the left side, and about parallel with it. On the morning of the third day, when evacuations occurred both from the artificial anus and the rectum, it was stated by the mother of the patient that an immense number of round worms, "about two pounds" in all, had passed by the wound. There seemed little doubt to the operator that the obstruction had been caused by the worms. The case terminated fatally a few days later.

Abortive Treatment of Small-Pox by Salicylic Acid.

Dr. Edwin Rosenthal, acting on the article by Dr. Boyer, has employed salicylic acid in many cases of small-pox with good results. The formula employed by him is as follows:

R. Acidi salicylici, 1 drachm; spts. vini rectificati, $\frac{1}{2}$ ounce; misce et adde, elix. simplici q. s., 6 ounces. For the angina of variola, he uses in conjunction therewith, the following gargle of xylol, and finds it very satisfactory: R. Xylol, 1 drachm; gum acaciæ, 2 drachms; aq. menth. pip., 6 ounces. M. Ft. emulsio. Sig. Use as a gargle and mouth wash. He confirms the statement that salicylic acid in small-pox reduces the temperature, is sedative, and modifies the eruption.—*Medical Bulletin.*

Treatment of Pain by Mechanical Vibrations.

BOUDET de Paris (*Le Progres Medical*, February 5, 1881), proposes to treat neuralgias by means of mechanical vibrations, claiming that mechanical shocks frequently repeated, determine local anæsthesia and analgesia. He applies a diaphragm set in vibration by an electric current of feeble intensity, directly to the surface to be affected. The maximum effect is obtained where the nerve is most easily compressed between the bone and the vibrating disc. In cases of very acute migraine, rapid vibrations communicated to the cranial parieties, lead to rapid relief at the end of a few minutes, and in case the remedy is tried early enough, cut short the attack entirely. Boudet thinks his means of treatment might be tried with advantage against the pains of locomotor ataxia. The plan is apparently similar in its action to the means proposed by Dr. Hammond for the treatment of neuralgia of the testis, which has proven so valuable in his hands.